

Public Health Case Record Checklist

Client: _____ DOB: _____ M-C ID: _____

Case Mgr: _____ Location: _____

Dates of
Service: _____

Review the case file to determine if the LGA identified the client's need(s). The client's need must meet at least one of following criteria/requirements to qualify for the Public Health target population:

Medi-Cal eligible high-risk persons identified as having a need for public health case management services including the following individuals:

- ☐ Women, infants, children and young adults to age 21
- ☐ Persons with HIV/AIDS
- ☐ Persons with reportable communicable diseases
- ☐ Pregnant women
- ☐ Persons who are technology dependent
- ☐ Persons who are medically fragile
- ☐ Persons with multiple diagnoses

Identify at least one of the service components used to assist the client in meeting their need(s):

☐ **Assessment** – must include the following as relevant to each individual:

- _____ Medical/mental condition
- _____ Training needs for community living
- _____ Vocational/educational needs
- _____ Physical needs, such as food & clothing
- _____ Social/emotional status
- _____ Housing/physical environment
- _____ Familial/social support system

☐ **Comprehensive Service Plan** – must include the following:

- _____ Actions required to meet identified service needs
- _____ Community programs, persons, and/or agencies to which the beneficiary will be referred
- _____ Description of the nature, frequency, and duration of the activities and specific strategies to achieve service outcomes

☐ **Linkages, Consultations, and Referrals**

☐ **Follow-up**, required within 30 days, to include the following:

- _____ Beneficiary received referral services
- _____ Services met the beneficiary's needs

☐ **Assistance in Accessing Services** – must include one of the following:

- _____ Arranging appointments and/or transportation to medical, social, educational, and other services
- _____ Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or service providers(s)

☐ **Crisis Assistance Planning** – must include one of the following:

- _____ Evaluates, coordinates, and arranges immediate service or treatment needed to avoid, eliminate, or reduce a crisis situation

☐ **Periodic Review**

- _____ Completed at least every six months
- _____ Conducted by the case manager in consultation with the beneficiary
- _____ Approved by the case manager's supervisor

Outpatient Clinics Case Record Checklist

Client:

DOB:

M-C ID:

Case Mgr:

Location:

Dates of
Service:

Review the case file to determine if the LGA identified the client's need(s). The client's need must meet at least one of following criteria/requirements to qualify for the Outpatient Clinics target population:

Medi-Cal eligible persons who are in need of outpatient clinic medical services and who need case management services in connection with their treatment because they are unable to access or appropriately use services, including individuals who:

- ☐ Have demonstrated noncompliance with their medical regimen
- ☐ Are unable to understand medical directions because of language or other comprehension barriers
- ☐ Have no community support system to assist in follow-up care at home
- ☐ Require services from multiple health care/social service providers in order to maximize health outcomes

Identify at least one of the service components used to assist the client in meeting their need(s):

☐ **Assessment** – must include the following as relevant to each individual:

- _____ Medical/mental condition
- _____ Training needs for community living
- _____ Vocational/educational needs
- _____ Physical needs, such as food & clothing
- _____ Social/emotional status
- _____ Housing/physical environment
- _____ Familial/social support system

☐ **Comprehensive Service Plan** – must include the following:

- _____ Actions required to meet identified service needs
- _____ Community programs, persons, and/or agencies to which the beneficiary will be referred
- _____ Description of the nature, frequency, and duration of the activities and specific strategies to achieve service outcomes

☐ **Linkages, Consultations, and Referrals**

☐ **Follow-up**, required within 30 days, to include the following:

- _____ Beneficiary received referral services
- _____ Services met the beneficiary's needs

☐ **Assistance in Accessing Services** – must include one of the following:

- _____ Arranging appointments and/or transportation to medical, social, educational, and other services
- _____ Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or service providers(s)

☐ **Crisis Assistance Planning** – must include one of the following:

- _____ Evaluates, coordinates, and arranges immediate service or treatment needed to avoid, eliminate, or reduce a crisis situation

☐ **Periodic Review**

- _____ Completed at least every six months
- _____ Conducted by the case manager in consultation with the beneficiary
- _____ Approved by the case manager's supervisor

Public Guardian Case Record Checklist

Client: _____ DOB: _____ M-C ID: _____

Case Mgr: _____ Location: _____

Dates of
Service: _____

Review the case file to determine if the LGA identified the client's need(s). The client's need must meet at least one of the following criteria/requirements for the Public Guardian target population:

Medi-Cal eligible individuals who are 18 years or older:

- ☐ who have exhibited an inability to handle personal, medical, or other affairs; or
- ☐ who are under conservatorship of a person and/or estate or a representative payee.

Identify at least one of the service components used to assist the client in meeting his or her need(s):

☐ **Assessment** – must include the following as relevant to each individual:

- _____ Medical/mental condition
- _____ Training needs for community living
- _____ Vocational/educational needs
- _____ Physical needs, such as food & clothing
- _____ Social/emotional status
- _____ Housing/physical environment
- _____ Familial/social support system

☐ **Comprehensive Service Plan** – must include the following:

- _____ Actions required to meet identified service needs
- _____ Community programs, persons, and/or agencies to which the beneficiary will be referred
- _____ Description of the nature, frequency, and duration of the activities and specific strategies to achieve service outcomes

☐ **Linkages, Consultations, and Referrals**

☐ **Follow-up**, required within 30 days, to include the following:

- _____ Beneficiary received referral services
- _____ Services met the beneficiary's needs

☐ **Assistance in Accessing Services** – must include one of the following:

- _____ Arranging appointments and/or transportation to medical, social, educational, and other services
- _____ Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or service providers(s)

☐ **Crisis Assistance Planning** – must include one of the following:

- _____ Evaluates, coordinates, and arranges immediate service or treatment needed to avoid, eliminate, or reduce a crisis situation

☐ **Periodic Review**

- _____ Completed at least every six months
- _____ Conducted by the case manager in consultation with the beneficiary
- _____ Approved by the case manager's supervisor

Aging and Adult Services/Linkages Case Record Checklist

Client:

DOB:

M-C ID:

Case Mgr:

Location:

Dates of

Service:

1. Review the case file to determine if the LGA identified the client's need(s). The client's need must meet at least one of the following criteria/requirements for the Linkages target population:

- ☐ Medi-Cal eligible individuals who are 18 years or older, in frail health, and in need of assistance to access services in order to keep them from becoming institutionalized.

2. Identify at least one of the service components used to assist the client in meeting his or her need(s):

- ☐ **Assessment** – must include the following as relevant to each individual:

- _____ Medical/mental condition
- _____ Training needs for community living
- _____ Vocational/educational needs
- _____ Physical needs, such as food & clothing
- _____ Social/emotional status
- _____ Housing/physical environment
- _____ Familial/social support system

- ☐ **Comprehensive Service Plan** – must include the following:

- _____ Actions required to meet identified service needs
- _____ Community programs, persons, and/or agencies to which the beneficiary will be referred
- _____ Description of the nature, frequency, and duration of the activities and specific strategies to achieve service outcomes

- ☐ **Linkages, Consultations, and Referrals**

- ☐ **Follow-up**, required within 30 days, to include the following:

- _____ Beneficiary received referral services
- _____ Services met the beneficiary's needs

- ☐ **Assistance in Accessing Services** – must include one of the following:

- _____ Arranging appointments and/or transportation to medical, social, educational, and other services
- _____ Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or service providers(s)

- ☐ **Crisis Assistance Planning** – must include one of the following:

- _____ Evaluates, coordinates, and arranges immediate service or treatment needed to avoid, eliminate, or reduce a crisis situation

- ☐ **Periodic Review** – must include the following:

- _____ Completed at least every six months
- _____ Conducted by the case manager in consultation with the beneficiary
- _____ Approved by the case manager's supervisor

Adult Probation Case Record Checklist

Client: _____ DOB: _____ M-C ID: _____

Case Mgr: _____ Location: _____

Dates of
Service: _____

1. Review the case file to determine if the LGA identified the client's need(s). The client's need must meet at least one of the following criteria/requirements for the Adult Probation target population:

- ☐ Medi-Cal eligible persons who are 18 years of age or older on probation who have a medical and/or mental condition and are in need of assistance in accessing and coordination of medical, social, and other services.

2. Identify at least one of the service components used to assist the client in meeting his or her need(s):

- ☐ **Assessment** – must include the following as relevant to each individual:

- _____ Medical/mental condition
- _____ Training needs for community living
- _____ Vocational/educational needs
- _____ Physical needs, such as food & clothing
- _____ Social/emotional status
- _____ Housing/physical environment
- _____ Familial/social support system

- ☐ **Comprehensive Service Plan** – must include the following:

- _____ Actions required to meet identified service needs
- _____ Community programs, persons, and/or agencies to which the beneficiary will be referred
- _____ Description of the nature, frequency, and duration of the activities and specific strategies to achieve service outcomes

- ☐ **Linkages, Consultations, and Referrals**

- ☐ **Follow-up**, required within 30 days, to include the following:

- _____ Beneficiary received referral services
- _____ Services met the beneficiary's needs

- ☐ **Assistance in Accessing Services** – must include one of the following:

- _____ Arranging appointments and/or transportation to medical, social, educational, and other services
- _____ Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or service providers(s)

- ☐ **Crisis Assistance Planning** – must include one of the following:

- _____ Evaluates, coordinates, and arranges immediate service or treatment needed to avoid, eliminate, or reduce a crisis situation

- ☐ **Periodic Review**– must include the following:

- _____ Completed at least every six months
- _____ Conducted by the case manager in consultation with the beneficiary
- _____ Approved by the case manager's supervisor

Community Case Record Checklist

Client: _____ DOB: _____ M-C ID: _____

Case Mgr: _____ Location: _____

Dates of
Service: _____

Review the case file to determine if the LGA identified the client's need(s). The client's need must meet at least one of following criteria/requirements to qualify for the Community target population:

Medi-Cal eligible adults and children at risk of abuse and unfavorable developmental, behavioral, psychological, or social outcomes, including individuals who:

- ☐ Abuse alcohol or drugs, or both
- ☐ Are at risk of physical, sexual, or emotional abuse
- ☐ Are at risk of neglect

Identify at least one of the service components used to assist the client in meeting their need(s):

☐ **Assessment** – must include the following as relevant to each individual:

- _____ Medical/mental condition
- _____ Training needs for community living
- _____ Vocational/educational needs
- _____ Physical needs, such as food & clothing
- _____ Social/emotional status
- _____ Housing/physical environment
- _____ Familial/social support system

☐ **Comprehensive Service Plan** – must include the following:

- _____ Actions required to meet identified service needs
- _____ Community programs, persons, and/or agencies to which the beneficiary will be referred
- _____ Description of the nature, frequency, and duration of the activities and specific strategies to achieve service outcomes

☐ **Linkages, Consultations, and Referrals**

☐ **Follow-up**, required within 30 days, to include the following:

- _____ Beneficiary received referral services
- _____ Services met the beneficiary's needs

☐ **Assistance in Accessing Services** – must include one of the following:

- _____ Arranging appointments and/or transportation to medical, social, educational, and other services
- _____ Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or service providers(s)

☐ **Crisis Assistance Planning** – must include one of the following:

- _____ Evaluates, coordinates, and arranges immediate service or treatment needed to avoid, eliminate, or reduce a crisis situation

☐ **Periodic Review**

- _____ Completed at least every six months
- _____ Conducted by the case manager in consultation with the beneficiary
- _____ Approved by the case manager's supervisor

Encounter Log Checklist

Verify if the following items from the encounter log match the client's case record(s):

	YES	NO	COMMENTS
Client's full name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Date of Birth: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medi-Cal ID/SSN: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____
Case Mgr Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Case Manager's Signature/Initials on Encounter Log: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Type of Contact (Circle One):

Office

Clinic

Home

Phone:

Is there an explanation? _____

Why was contact by phone?

Other:

Does a description exist? _____

Type of Services Provided:

- ☐ Assessment
- ☐ Comprehensive Service Plan/ Individual Service Plan
- ☐ Linkages, Consultation/Referral Services(requires a 30 day follow up)
- ☐ Assistance in Accessing Services
- ☐ Crisis Assistance Planning
- ☐ Periodic Review (requires supervisor's signature on service plan amendment)